IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Williamson v. Wang,*
2024 BCSC 1227

Date: 20240709
Docket: S212810
Registry: Vancouver

Between:

Javecia Williamson

Plaintiff

And

Dr. Jing Jane Wang

Defendant

Before: The Honourable Justice Wilson

Reasons for Judgment

Counsel for the Plaintiff:	V.L. Medved S. Collins
Counsel for the Respondent:	M.K. Gill N.M. Cooke
Place and Date of Trial/Hearing:	Vancouver, B.C. April 8–12, 15–18, 23, 24 and 26, 2024
Place and Date of Judgment:	Vancouver, B.C. July 9, 2024

[1] This case is about an unsuccessful attempt by the defendant anaesthesiologist to administer an obstetric epidural to the plaintiff who was expecting her first child. The epidural needle broke during the attempt and the retained fragment had to be surgically removed.

[2] The plaintiff was expecting her first child in March 2019. On March 25, 2019, she was admitted to Surrey Memorial Hospital to give birth, where she requested an epidural anesthetic. The plaintiff's attending nurse contacted the on-shift anesthetist, the defendant Dr. Wang.

[3] Dr. Wang tried without success to get the needle into the plaintiff's epidural space. The needle broke, leaving a portion of the needle in the plaintiff's back. Dr. Wang successfully removed the needle tip shortly after it broke.

[4] The plaintiff asserts that Dr. Wang was negligent in her administration of the epidural. She says her injury was not caused by the broken needle fragment that needed to be excised from the plaintiff's back; rather, the injury was caused by the defendant's use of excessive force in the manipulations of the needle by way of numerous redirections, resulting in damage to the tissue. The plaintiff argues the needle breaking was not causative of her injuries, but is confirmatory of her theory of the case.

[5] The plaintiff says that she has had significant back pain ever since the failed attempt, and she brings this claim for compensation for her injuries.

[6] The defendant argues that the plaintiff's claim must be dismissed because the plaintiff failed to establish that the defendant did not meet the standard of care when attempting to administer the epidural.

[7] The defendant also argues that even if she did not meet the standard of care, her actions were not a cause of the plaintiff's ongoing symptoms. As such, the plaintiff's damages should be limited to compensation for the brief and uncomplicated surgical procedure required to excise the needle fragment.

[8] Both parties called anaesthesiologists who were qualified to give expert evidence regarding the standard of care.

[9] The plaintiff's expert anaesthesiologist, Dr. Darren Ezer, opined that Dr. Wang used excessive force in the epidural attempt and, by so doing, she failed to meet the standard of care. Dr. Ezer also says that by undertaking the surgical excision herself, Dr. Wang was outside the normal scope of work for an anaesthesiologist. The defendant's expert, Dr. Steven Head, did not agree. The plaintiff ultimately concedes that the excision was entirely successful and that nothing turns on the question of who should have done the removal.

The Parties

Plaintiff

[10] Ms. Williamson was born in Jamaica on April 15, 1991. She moved to Canada in 2006 and currently lives in Langley with her husband, Mr. Carlo Welsh, and their two children, CJ, born in March, 2019, and a daughter born in August, 2020.

[11] She is presently 33 years old, stands 5’1” and weighs approximately 139 lbs.

[12] Ms. Williamson attended Douglas College for two years prior to transferring to Simon Fraser University where she earned a diploma and bachelor’s degree in criminology, respectively. Upon completing her bachelor's degree in October 2016, Ms. Williamson entered the work force full-time for a recruiting firm.

[13] The incident that is the subject of this claim relates to CJ’s birth. Ms. Williamson found out she was pregnant with CJ in the summer of 2018. She testified that her family physician, Dr. Mathew, recommended a midwife who could advise on what to expect and provide care throughout the pregnancy. It was always the plaintiff’s intention to deliver in a hospital.

[14] Ms. Williamson testified that she was healthy, active and had no issues prior to her pregnancy. During her pregnancy, Ms. Williamson testified that she was free of symptoms, full of energy and was excited to become a mother. It was Ms. Williamson’s

evidence that she did not experience any back pain, continued to work full-time and had no work accommodations due to her pregnancy. Ms. Williamson's original due date was March 10 to 17, 2019, but despite going past her due date she continued to remain active.

[15] The plaintiff said she gained between 40 and 50 pounds during her pregnancy, but none of her medical practitioners expressed concern as it was known that she would be having a larger baby. CJ weighed 9 lbs 6 ounces at birth.

[16] Ms. Williamson found her first week at home to be difficult. She was in pain, could not go up the stairs and could not sleep on her back or front because of surgery. She had difficulty with breastfeeding as well because of her back pain. Ms. Williamson received help from her family including from Mr. Welsh.

[17] After a couple of months, the plaintiff says she was still experiencing sharp pains in the area where the needle had broken. Her activities of daily life were limited and she was unable to do the things she did previously. Mr. Welsh was doing 80% of the chores and her mother helped where she could. If she tried to increase her activities, Ms. Williamson's pain would become more intense and more painful, accompanied with a burning sensation and some throbbing.

[18] Ms. Williamson became pregnant with her second child in December 2019. She described experiencing mixed feelings and emotions about the pregnancy. She testified that she felt grateful as she always wanted a large family, but was concerned about her back and the daily pain. She also started to worry about the labour and delivery.

[19] Ms. Williamson contacted Dr. Mathew to advise of the pregnancy. She conveyed that she was traumatized from her prior delivery experience and relayed that her back was not better. Dr. Mathew referred her to an obstetrician and arranged for her to have anesthetic consultation well in advance of the anticipated birth.

[20] As her pregnancy progressed, the plaintiff recalls her back feeling worse which was worrisome to her. Ms. Williamson decided to deliver at Peace Arch . She had a

spinal anesthetic and gave birth to her second child via caesarian section in August, 2020.

[21] Ms. Williamson continued to report to Dr. Mathew that she had back pain in the area where the epidural needle had broken and that she was extremely uncomfortable. Ms. Williamson had an MRI performed to investigate further.

[22] Following the MRI, Dr. Mathew confirmed with Ms. Williamson that there was no needle particle in her back and that everything had been removed. The MRI revealed degenerative changes in the plaintiff's lumbar region.

[23] The plaintiff recounted that she was still feeling a lot of shooting pain in her back between 2021 and September 2022. She had a consultation with a neurosurgeon who concluded that he did not feel surgery was needed.

[24] Ms. Williamson's pain is in her back right above the belt line where the epidural was done. She described the pain as running the whole length of her flank and going up into the shoulder blades to the bra line and into the spine. Ms. Williamson also experiences, on and off again, sharp shooting pains down both her legs. The leg pain occurs approximately two or three times per year—most recently in December 2023.

[25] Dr. Mathew ordered two subsequent MRIs in response to the plaintiff's various symptoms. The results from the second are largely consistent with the findings from the first. The third MRI was shortly before the trial, but the results were not available.

[26] The plaintiff and Mr. Welsh were living with her mother, her brother and his wife, Winnie Williamson, at the time of these events. She and Mr. Welsh subsequently moved into their own home in May 2021 with their young family. She no longer works as a recruiter, and has more recently done some office administration work at an accounting firm where her brother works. She is presently completing a medical office assistant program and hopes to secure work in that field in the near future. She does not claim to have lost any income.

[27] The plaintiff seeks nonpecuniary damages for her pain and suffering, both past and prospective. She also seeks cost of future care, which includes psychological counselling, occupational therapy, adjunctive therapy such as physiotherapy and massage, plus medications. The plaintiff claims a small amount under the *Health Care Costs Recovery Act,* S.B.C. 2008, c. 27.

Defendant

[28] Dr. Jane Wang obtained a bachelor of science in pharmacology from UBC in 2006 and then went to the University of Toronto to get her Doctor of Medicine. She remained in Toronto for her anesthesiology residency at the University of Toronto from 2010 to 2015, including at Mount Sinai Hospital.

[29] Her residency training included obstetrics at various times through her course, with the core obstetric training in her second year. She received her designation from the Royal College of Physicians and Surgeons in 2015, having passed a number of exams, and returned to British Columbia.

[30] Dr. Wang has been practicing as an anesthesiologist in British Columbia since 2015 and at Surrey Memorial Hospital full-time since 2017.

Legal Principles of Medical Malpractice

[31] The parties agree to the general principles to be applied in this case. A claim of medical negligence is no different than any other claim framed in negligence. In order to succeed, the plaintiff needs to establish: (a) that the defendant owed the plaintiff a duty of care; (b) that the defendant's conduct breached the applicable standard of care; (c) that the plaintiff sustained damage; and, (d) that the damage was caused, in fact and in law, by the defendant's breach: *Mustapha v. Culligan of Canada Ltd*., 2008 SCC 27 at para. 3.

[32] There is no question here that Dr. Wang owed a duty of care to the plaintiff.

[33] There is also no doubt that the plaintiff has experienced and will continue to experience pain in her lower back. Not only has the plaintiff testified as to her ongoing symptoms, none of the expert witnesses have suggested otherwise.

[34] This case therefore turns on the second and fourth aspects of the test as set out above:

a) Did Dr. Wang's conduct breach the standard of care?

b) If yes, were the plaintiff's injuries caused by Dr. Wang's conduct?

[35] If the plaintiff is successful in her claim regarding liability, the question turns to what are the plaintiff's damages.

Background Facts

What is an Epidural?

[36] Dr. Ezer and the defendant both testified as to how an epidural procedure is performed.

[37] An epidural anesthetic is a procedure that involves inserting a hollow needle that passes through the skin, followed by the subcutaneous layer, which is primarily fatty tissue, followed by ligamentous, through various ligaments before reaching the epidural space. In order to reach the epidural space, the anesthetist must manipulate the needle through the various layers, but more significantly, must also navigate between the bony structures in the spine.

[38] Once the needle is within the epidural space, it is replaced with a catheter through which the anaesthetic is administered and monitored for the duration of the procedure. Although this was an obstetric epidural, they are also used for other situations, including for surgical procedures.

[39] An epidural is administered into the lumbar spine. The needle used in this case, and routinely in epidurals throughout Canada and elsewhere, is the 17-gauge Tuohy

needle. The needle contains a stylet at the time of insertion, which is removed after the needle has passed through the skin and into the subcutaneous tissue.

[40] An epidural is generally administered using what is referred to as a ‘blind technique’. That is, the anaesthesiologist cannot “see” where the needle is going, nor can they see when the needle has entered the epidural space. In order to initiate the process, the anesthetist attempts to locate spaces in the bony structures of the spine by palpating, or touching, the patient’s low back.

[41] In order to assist with the process, the patient is positioned in a manner so as to open up the spaces between the bony structures in the spine. In the majority of cases, the patient sits on the side of the hospital bed with their feet dangling and bends forward as far as possible.

[42] In order to ascertain whether the tip of the needle is in the epidural space, anaesthesiologists use what is referred to as the ‘resistance technique’. This technique involves an evaluation by the anesthetist based upon the resistance to the tip of the needle as it is advanced into the patient in small increments.

[43] The 17-gauge Tuohy needle is relatively blunt when compared to other needles of higher gauges that are used in the medical profession. The patient’s skin is frozen with lidocaine prior to insertion of the needle. The skin offers some resistance to the needle, but there is less resistance in the subcutaneous tissue. The needle then enters into and passes through the ligaments, which are tougher and offer greater resistance. The anesthetist infers that the tip of the needle is in the epidural space when the resistance offered by the ligaments ends and the needle is then subject to no resistance upon advancement.

[44] If the anaesthesiologist is unable to successfully administer the epidural at a particular location in the patient's back, they will sometimes withdraw the needle entirely and try again at another location. These are referred to as “attempts”. If the needle hits bone or otherwise cannot be advanced, the anesthetist may change the angle or otherwise manipulate the needle to direct the needle tip in a different direction. These

changes in direction, where the needle is not fully removed and then reinserted through the skin, are called “redirections”.

[45] It is not unusual for an attempt to administer an epidural to be unsuccessful. Approximately one in eight epidurals is not successful, in which case some other pain control procedure is used.

The Incident

[46] On March 24, 2019, the plaintiff went to Surrey Memorial Hospital to have her labour induced as she was past her due date. She was provided intravenous (“IV”) oxytocin for the purpose of initiating labour between 9:00 and 9:30 pm. She began feeling contractions that increased with intensity. Nurse Satinder Dhindsa and Mr. Welsh were with her in the hospital room. The plaintiff’s midwife was present earlier in the evening but left for the night and told the plaintiff she would return in the morning.

[47] Sometime prior to 5:00 am, the plaintiff’s labour contractions were becoming very strong and intense. They were two to three minutes apart and would last sixty seconds or so. She told Nurse Dhindsa that she was ready for the epidural. The nurse said she would step out and find the on-call anaesthesiologist, which turned out to be Dr. Wang.

[48] Dr. Wang came into the room at approximately 5:00 am. After preparing the needle and ensuring that the plaintiff was appropriately positioned, Dr. Wang made her first attempt to administer the epidural. It was not successful because the needle struck a blood vessel. She then tried again at a different location in the plaintiff’s back. At approximately 5:15 am, as she was withdrawing the needle, Dr. Wang noted that the needle had broken and that the tip was retained in the plaintiff’s back.

[49] After feeling the needle tip in the plaintiff’s back with her finger, Dr. Wang directed a nurse to bring a scalpel, Kelly instrument—a tool that is like a pair of scissors with tweezers at the end—and suturing kit. Dr. Wang made a vertical incision in the skin and then extracted the needle tip with the Kelly instrument. She then sutured the incision. In total, Dr. Wang applied five stitches. She then directed the nurse to put in an IV for antibiotics, using the same antibiotics as would be used for spinal surgery.

[50] The entire procedure, including the removal of the retained needle tip, was completed by 5:30 am, approximately 30 minutes after Dr. Wang first entered the plaintiff's room.

[51] This case turns on the events between 5:00 and 5:30 am in the plaintiff's hospital room, and whether the manner in which Dr. Wang attempted to administer this obstetric epidural to the plaintiff met the required standard of care.

[52] This case is not about whether an epidural was an appropriate pain management technique in the circumstances, nor is it a case about whether the plaintiff gave informed consent for the procedure. Epidurals are routinely used across North America for pain management for labouring women.

[53] The plaintiff and her husband gave a different account of what happened that morning than did Dr. Wang. They described Dr. Wang as hurried and dismissive, and that she did not stop the epidural even when the plaintiff was crying out in pain and calling for her to stop.

[54] Ms. Williamson testified that at approximately 5:00 am, she was laying in the hospital bed when Dr. Wang rushed into her room pushing a cart "very quickly". She recalled Dr. Wang telling Nurse Dhindsa it was a busy night, telling her to sit at the edge of her bed hugging a pillow and telling Mr. Welsh to stand in front of her for support, pulling her shoulders forward. She said that Dr. Wang told her the epidural would take about 30 seconds, and that it was important for her to stay still. She advised that there was a risk the epidural would cause headaches. The plaintiff testified that upon Dr. Wang's arrival, she did not introduce herself, nor did she confirm the plaintiff's name or date of birth, did not ask her how far apart her contractions were or how long her contractions were lasting. Dr. Wang did not provide any instructions on what to do if she were having a contraction. Dr. Wang was to the point and snappy with instructions, which did not leave any room for communication. It was Ms. Williamson's evidence that they barely spoke to each other.

[55] Ms. Williamson's evidence was that Dr. Wang made four attempts to administer the epidural. Ms. Williamson testified to barely feeling the first needle insertion. She recounted that she did not feel pain but did feel pressure, all of which were manageable. Ms. Williamson recalls Dr. Wang pulling the needle out and telling the nurse that it did not work.

[56] The second attempt was different. The plaintiff said Dr. Wang felt her lower back at the second location and without notice, forcefully rammed the needle into her back. She could feel pain and wanted to react, but the needle was already in. She described feeling the needle moving around, and it became very painful. She said she asked Dr. Wang to stop, but she did not.

[57] The third attempt was much more painful than the second attempt. Ms. Williamson was not able to tolerate the pain. Ms. Williamson described feeling helpless because Dr. Wang did not stop after she asked her to. Ms. Williamson advised Dr. Wang that she was having a contraction, and she still did not stop. Towards the end of the contraction, Dr. Wang pulled the needle out and by that point Ms. Williamson was crying out loud.

[58] It is Ms. Williamson's evidence that Dr. Wang put the needle in and took it out on three separate occasions at the second location. Ms. Williamson testified to feeling Dr. Wang moving the needle up, down and "around and around" while the needle was inserted in her back. This made the procedure a lot more painful for Ms. Williamson.

[59] At the last insertion, Ms. Williamson could hear instruments moving on the cart, and was told by Dr. Wang to sit still, as she rammed the needle in again. Ms. Williamson yelled out loudly and felt like the needle hit something as soon as it was inserted. She felt a very sharp pain and started screaming. Ms. Williamson heard Dr. Wang tell the nurse that half of the needle was in her back, at which point Ms. Williamson began crying.

[60] Ms. Williamson states that the pain felt during the epidural process was different than her contraction pains. She gave evidence that the contraction pain was intense,

like a bad menstrual cramp, in the lower pelvic area and that the epidural needle pain was sharp and in the lower back.

[61] Ms. Williamson's evidence is that she asked Dr. Wang to stop during the second and third insertion attempts.

[62] Mr. Welsh described being able to see Dr. Wang maneuvering the needle while the tip was in his wife's back, and seeing four distinct attempts to administer the epidural. Because he was standing in front of the plaintiff and she had her head on his chest in order to maintain the proper positioning for the epidural, he could see her back and what Dr. Wang was doing. His evidence corroborates the plaintiff's version of events.

[63] Dr. Wang has very little specific recollection of the events prior to when the needle broke, and as such her evidence as to that time frame was limited to her standard practice, assisted by her chart notes. She did not recall receiving a phone call from Nurse Dhindsa; however, typically the nurse or doctor that calls her will advise her of the patient's name and what room they are in. Dr. Wang's practice is to ask the nurse additional questions if the information is not volunteered to ascertain the urgency of the epidural, the gestational age of the patient, the reason for the admission, the dilation, and what other pain management modalities she has already tried.

[64] Dr. Wang's standard practice is to introduce herself, advise she is the anesthesiologist, and adjust the patient's bed position upon arrival. She adjusts the height of the bed when standing to perform an epidural so that she will be able to reach her arm to the patient's L2—L4 level. Dr. Wang directs the patient to move back in the bed and cross their legs. She then directs the patient to bend forward, and to put their head on the support person's chest.

[65] Dr. Wang then reviews the chart to identify the triage note that includes information about the patient and an overview of a patient's vitals, medical history, allergies, and medication.

[66] Dr. Wang used the standard epidural kit supplied by Surrey Memorial Hospital. Her standard practice is to inspect the epidural kit prior to commencing the epidural insertion to see that each piece is working well. Dr. Wang gave evidence that when a patient has been positioned sitting upright on the bed, she applies a plastic drape to the patient's back and lets the patient know she is going to feel a hand touching their back and a prick of freezing going in.

[67] Dr. Wang terminated the first attempt when she encountered blood. On the second attempt, which was at the L3–L4 level, she applied 2% lidocaine and reinserted the needle and stylet to a depth of four centimetres, as she knew when she had encountered blood at four centimetres on the prior attempt that she had not reached the epidural space. When Dr. Wang could feel the increase in resistance from the ligaments, she detached the stylet, attached the glass syringe, and started the loss of resistance technique using two hands. She continued to make advancements. Her practice is to advance less than 0.5 mm at a time. She conceded that there may have been a few re-directions of the needle during this attempt, and agreed that she encountered bone during some of the advances of the needle.

[68] When Dr. Wang had advanced the needle to a depth of six-and-a-half centimetres, she felt she was close to the epidural space. She testified that Ms. Williamson had a contraction at that point and arched her back backwards. Dr. Wang waited for Ms. Williamson to regain composure and return to her position. Dr. Wang then continued her advancement technique but hit bone. She started to withdraw the needle, but felt a loss of resistance. She noted that the needle tip had broken off and remained in Ms. Williamson's subcutaneous tissue.

[69] After the needle broke, Dr. Wang immediately informed the nurse and Ms. Williamson. She used a scalpel to make a small incision, removed the retained tip, and sutured the wound.

[70] Following a failed spinal anaesthetic attempted by a different anaesthesiologist, the plaintiff delivered a healthy baby boy by caesarean section while under a general anaesthetic.

Credibility and Reliability

[71] This case turns in part on the *viva voce* evidence tendered at trial. As such, I must assess the credibility and reliability of each witness.

[72] Credibility and reliability of witnesses are separate concepts. Credibility relates to honesty, whereas reliability relates to accuracy. A witness who is not credible on an issue cannot give reliable evidence on that issue; however, a credible witness may give unreliable evidence: *R. v. H.C*., 2009 ONCA 56 at para. 41.

[73] In *Bradshaw v. Stenner,* 2010 BCSC 1398 at para. 186*,* this Court stated the following principles for evaluating the credibility of witnesses:

> Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Faryna v. Chorny*, 1951 CanLII 252 (BC CA), [1952] 2 D.L.R. 354 (B.C.C.A.) [*Faryna*]; R. v. S.(R.D.), 1997 CanLII 324 (SCC), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Faryna* at para. 356).

[74] The Court went on at para. 187 to set out an appropriate approach in order to determine whether to accept a witness' evidence:

> It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.*

> (1993), 1993 CanLII 7140 (AB QB), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.

[75] I will now address the credibility and reliability of the witnesses in making my findings of fact.

Nurse Dhindsa

[76] Nurse Dhindsa was a disinterested witness and called as part of the plaintiff's case.

[77] Ms. Dhindsa provided her evidence in a very clear, concise and consistent manner. She was clearly able to articulate and distinguish those things that she actually remembered from those that she did not, and she did not speculate or attempt to fill in any gaps in her recollection. She testified in a forthright manner, and provided her evidence to the best of her ability.

[78] I accept Ms. Dhindsa's evidence in its entirety.

Plaintiff

[79] There were some inconsistencies in the plaintiff's evidence. I will refer to a few of them.

[80] The plaintiff, for example, testified that she had no issues or typical pregnancy symptoms during her first pregnancy—no morning sickness, fatigue, neck pain or back pain. She said she wore high-heeled shoes up until she gave birth, remained active during pregnancy, and worked fulltime without accommodation. However, she submitted a form to her employer requesting that she be permitted to work from home as opposed to going into the office:

> Currently in my sixth month of pregnancy and having a lot of back pain> [sic] I am unable to sit for more than 5 hours on the chair at work so I rather work from home where I have a comfortable chair and desk.

[81] Although she initially admitted to having sent the document to her employer, she subsequently denied having signed it and denied any recollection of it.

[82] Ultimately, the Court was not provided with an explanation for the document. Either the plaintiff was experiencing back pain prior to this incident, which might tend to undermine her argument as to causation, or perhaps it was simply a false premise to justify a request to work from home. Neither would assist in an assessment of her credibility. In so saying, I note the plaintiff had a minor motor vehicle accident in February 2019 and noted no back pain when she attended at the hospital related to concerns about her baby, and I accept that she continued to work fulltime until she gave birth.

[83] There were other aspects of Ms. Williamson's evidence that would call in to question the reliability of her evidence. She testified that she had a vaginal exam at 3:00 am and was four to five centimetres dilated before the epidural insertion. However, her evidence was contradicted by Nurse Dhindsa, who testified that Ms. Williamson declined all vaginal examinations because she found them uncomfortable. Nurse Dhindsa, who came on shift at 7:30 pm, did not conduct a vaginal examination of the plaintiff at any time.

[84] As for the epidural attempt itself, the plaintiff was adamant there were four distinct attempts; however, since the procedure was in her back, I conclude that she would not be able to distinguish between an attempt and a redirection given that her skin had been frozen with lidocaine.

[85] A couple of days after the failed epidural, on March 27, Dr. Wang went to see the plaintiff to provide her with some pre-discharge instructions, including with regard to the sutures in her back. The plaintiff testified that Dr. Wang never apologized in any way for what had happened. Unbeknownst to Dr. Wang, the plaintiff and Mr. Welsh recorded the conversation. The recording was played during the trial, and Dr. Wang said the word 'sorry' over 20 times.

[86] There can be no doubt that this experience would have been a horrifying and traumatic one for Ms. Williamson. She was already in a great deal of pain, and was understandably anxious about a significant event—the birth of her first child. She felt that Dr. Wang was insufficiently concerned or attentive, and endured a wholly

unanticipated complication with the unfortunate event of the needle fracture, followed by an additional unanticipated surgical procedure on no notice.

[87] With the exception of my earlier comment about her lack of recollection regarding her request for accommodations at work, I conclude that Ms. Williamson was a credible witness, but I do not find that her evidence regarding the events on the morning of March 25, 2019, to be reliable in all of the circumstances.

Mr. Welsh

[88] Mr. Welsh's recollection of events was identical to that of the plaintiff, even with regard to matters where I did not accept her evidence.

[89] Mr. Welsh's recollection of events when Dr. Wang arrived at Ms. Williamson's room was very detailed and identical to that of his wife. He testified that Dr. Wang was in a rush and came in quickly pushing a cart. He said that Dr. Wang did not mention anything about risks but did say the epidural might cause a prolonged headache, and that his wife should not move. Lastly, he said that Dr. Wang told them that the procedure would take 30 seconds, exactly as his wife had testified.

[90] I find that it is highly improbable that Dr. Wang told them that the procedure would only take 30 seconds because both Dr. Wang and Nurse Dhindsa testified that the procedure takes much longer. I accept Dr. Wang's evidence that the reference to 30 seconds is that she advises a patient that there will be a time during the procedure that they must remain still for approximately 30 seconds in order to avoid an epidural headache.

[91] I do not accept that Mr. Welsh could see each of Dr. Wang's attempts to administer the epidural. First, although he testified to four attempts, I accept that there were only two. Both Dr. Wang and Nurse Dhindsa testified that the patient is always draped to try to reduce the possibility of infection, which necessarily obstructs the view of someone looking from above. Nurse Dhindsa, who acted as the support person for Ms. Williamson during suturing, testified that she could not see the suturing being done

from the same position as Mr. Welsh had been standing. Nurse Dhindsa said she would not be able to see unless she leaned to the side.

[92] I do accept that Mr. Welsh would have been able to see Dr. Wang's hands moving about under the drape. I find that he made assumptions as to what was going on under the drape from what he was able to observe, as opposed to actually observing the needle itself. Because he was not able to actually see the needle but only movements in Dr. Wang's hands, he would not have been able to distinguish between an attempt, when the needle was fully withdrawn from the skin and reinserted, and a redirection, when the needle tip is withdrawn to the subcutaneous tissue and advanced in a different direction.

[93] Similarly, I do not accept Mr. Welsh's evidence that he was able to see Dr. Wang change the angle of the needle by 20–30 degrees during what he called the fourth attempt. I accept that he could glean that Dr. Wang had changed the angle based on the position of her hands, but because he could not see the needle, he would not be able to see the degree of change in the angle of the needle itself.

[94] I have no doubt that seeing his wife undergo this failed epidural attempt would have been a frightening experience for Mr. Welsh. At some point after the needle broke but before Dr. Wang removed it, Mr. Welsh had to sit down and Nurse Dhindsa took over the support role for the plaintiff.

[95] Overall, I found Mr. Welsh to be a credible witness, in that I believe that he was telling the truth to the best of his ability, but there were some aspects of his evidence that I did not find to be reliable.

Dr. Wang

[96] Dr. Wang's actual recollection of the events that give rise to this claim were extremely limited prior to the needle fracture. As such, her evidence regarding events leading up to then was largely limited to her testifying about her standard practice in administering an epidural.

[97] The plaintiff argues that Dr. Wang was a difficult witness, raising concerns about the credibility of her evidence. She says that during both direct examination and re-examination, Dr. Wang's answers were concise and succinct, which contrasted with her responses in cross-examination which she argues were selective, evasive, non-responsive, meandering and argumentative.

[98] As an example, Dr. Wang consistently asserted that the epidural failed because of the plaintiff's elevated body mass index ("BMI"), short stature and tough ligaments. However, when she met with the plaintiff and Mr. Welsh on March 27, she had said that her BMI was not a problem. Dr. Wang explained that when she met with the plaintiff, she did not want to come across as blaming, but wanted to ensure that the plaintiff knew to explain to any future anesthetist who might be attempting an epidural as to what had happened, and that unlike an elevated BMI, tough ligaments and short stature are simply facts and not something the plaintiff could do anything about.

[99] I accept that Dr. Wang was a difficult witness in that she often gave long and meandering answers to questions. At times it appeared that she was reluctant to give unequivocal answers, and instead gave lengthy responses that incorporated additional possibilities or hypotheticals that had neither been incorporated into nor excluded from the question.

[100] Overall, and notwithstanding that her evidence took longer than might have been necessary, I found Dr. Wang to be a credible witness. Her answers, while lengthy and at times meandering and repetitive, remained consistent, and I did not find her to be either argumentative or selective.

Findings of Fact

[101] In terms of my findings of fact, I will start with the evidence of Nurse Dhindsa, whose evidence I accept.

[102] Ms. Dhindsa is a registered nurse at the family birthing unit in Surrey Memorial Hospital and was assigned to the plaintiff on the night of the events in question. Her shift started at 7:30 pm on March 24.

[103] Nurse Dhindsa testified that if the patient is in labour, the nursing is on a one-to-one basis. The nurse monitors, deals with pain medications, progress during labour, and assists with delivery if and when needed. In addition to monitoring, she prepares charts to record significant events as they occur.

[104] When Nurse Dhindsa took over the plaintiff's care she was already in her room and Mr. Welsh was also present. She was on oxytocin to induce labour. Once a patient is administered oxytocin, hospital staff use different monitors to assess their condition. These include a fetal heart rate monitor which is attached to the abdomen and a monitor that tracks the contractions which is placed on the top of the uterus. The latter monitor only determines when contractions take place and how long they last but there is no measure for intensity, as pain depends on the patient.

[105] Nurse Dhindsa described the plaintiff as trying the gas mask, but then refusing to use it. She recalls from her review of the notes that the plaintiff took a shower to assist with the pain at some point. The contractions progressed but remained at a moderate level. She was unable to conduct a vaginal examination because of the plaintiff's discomfort with the procedure. Nurse Dhindsa’s notes confirm that she was unable to conduct an examination and therefore was not in a position to say how dilated the plaintiff might have been. There was a note from the prior shift nurse indicating the plaintiff was one centimetre dilated, but Nurse Dhindsa was unable to assess dilation at any time.

[106] Nurse Dhindsa called for Dr. Wang. Dr. Wang asked Nurse Dhindsa to set up the plaintiff for the epidural because she had to do another one afterwards. She set up the patient, which means making her sit on the side of the bed with her legs dangling. Dr. Wang did not say that she was in a rush but did say she had another epidural to do, which is not unusual.

[107] Nurse Dhindsa sees approximately three epidurals in a four-shift rotation. When Dr. Wang arrived, her demeanour was normal. Nurse Dhindsa had no recollection of any discussions between Dr. Wang and the plaintiff, nor does she recall any discussions about risk, patient history or any communications about her positioning.

Dr. Wang instructed Mr. Welsh to stand in front of the plaintiff, who was to put her head on his chest, with his hands on her shoulders.

[108] Nurse Dhindsa was not involved in the epidural as it is not her procedure. As such, she was doing other tasks—she went to the nursing station on two or three occasions to get things—and does not otherwise engage in the epidural process. She saw Dr. Wang pushing or applying pressure to the needle, but this, in and of itself, is not unusual, and she is unable to say how much force was applied.

[109] From her notes, Nurse Dhindsa was able to ascertain that Dr. Wang came into the plaintiff's room at approximately 5:00 am, and the needle broke at approximately 5:15 am. Dr. Wang directed her to get a scalpel, needle blade and suture kit from the operating room area. She has no recollection of hearing any frustration from Dr. Wang, nor of any sudden jerky movements by the plaintiff. Nurse Dhindsa recalled the plaintiff mentioning once that she was in pain during the process. She has no recollection of the plaintiff voicing any particular concern or asking for the process to stop. She could not actually see Dr. Wang's hands, either during the epidural, or when the incision was sutured following extraction of the retained needle tip.

[110] Nurse Dhindsa has no recollection of Dr. Wang being hurried. She does recall Dr. Wang removing the fragment and Nurse Dhindsa saw that the needle fragment appeared complete, meaning that there was no piece left in the plaintiff's back. She recalls Dr. Wang saying she had never stitched anyone before. There was blood on the bed, more than normal, but it was not all over the room as the plaintiff had described in her evidence. Dr. Wang gave the plaintiff some intravenous fentanyl for the pain. Nurse Dhindsa recalls Dr. Wang saying that she would be late for her next epidural.

[111] Nurse Dhindsa had never been present for a needle break during an epidural. When the needle was removed, she saw that it was bent in half. She agrees that she had a nice rapport with the plaintiff and went to see her the next day to see how she was doing. She estimates that she was out of the room for five minutes of the period of time while the epidural was being attempted and before the needle broke.

[112] Nurse Dhindsa agreed that she rarely sees the needle after it is withdrawn following an epidural but this was an unusual case. The only reason she saw the needle in this case was because Dr. Wang showed it to her. It is not unusual for an anaesthesiologist to have another epidural to do, albeit she said it was not common that they would actually say so in front of the patient.

[113] Dr. Wang primarily testified about her standard epidural practice. Physicians will often have a standard practice or set of procedures they routinely follow in particular circumstances. In *Belknap v. Meakes* (1989), 64 D.L.R. (4th) 452 at 465–466, 1989 CanLII 5268 (B.C.C.A.), our Court of Appeal commented on the value of a professional's evidence of their standard practice and found that it may be given significant weight, even though the witness may have no specific recollection of the events in issue:

> If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question.
>
> *Wigmore on Evidence*, vol. IA (Tillers rev. 1983), states that there is no reason why habit should not be used as evidence either of negligent action or of careful action (para. 97), and that habit should be admissible as a substitute for present recollection. *Phipson on Evidence*, 13th ed. (1982), paras. 9-22, reaches a similar conclusion.

[114] However, a court is not bound to accept such evidence, and it may depend on the nature of that evidence. In *Gilmore v. Love*, 2023 BCSC 1380, Justice Marzari drew a distinction between evidence of what a physician routinely does on the one hand and what the physician thinks they would have done on the other:

> [80] Overall, while I have given weight to standard practice evidence in this case, I have only accorded the weight I considered appropriate based on the level of clarity and consistency of that evidence. I have given considerable weight to this evidence where the evidence was sufficiently clear or supported to reassure me that it described a consistent and largely unwavering practice. I have given much less weight to testimony that appeared to be a reconstruction of what the Defendant medical practitioners thought they would have done, or later came to understand they should have done.

[115] The plaintiff argues that the court ought not to accept Dr. Wang's evidence of her standard practice as evidence of what she did on this occasion because there were

examples of where she did not actually follow it in this case. I do not agree. First, although the plaintiff's evidence of her initial interactions with Dr. Wang when she first came into the room do not accord with what Dr. Wang described as her standard practice, I have already concluded that the plaintiff's evidence around this time is not particularly reliable. Second, the significance of the standard practice evidence in this case does not relate to the conversations or interactions between the parties, but rather the methodology or technique employed for the epidural attempt.

[116] As for the epidural attempt itself, Dr. Wang was largely dependent on her anesthetic record, which forms a part of the hospital records. The records indicate that her first attempt was made at the L2-L3 level. She used the lidocaine and followed her normal practice. She removed the stylet after the needle was inserted approximately three centimetres, but when it got to four centimetres, there was blood. Dr. Wang said this would not necessarily be painful but it does require the needle to be fully withdrawn, followed by another attempt. She would then have checked to make sure that all of the equipment is still functioning properly and then made another attempt.

[117] I accept that Dr. Wang's contemporaneous notes found in her anaesthetic record accurately reflect her observations of the events. It is extremely important that all treating medical practitioners make accurate notes of their observations because other treaters will be relying on those notes as part of the continuum of care. Anaesthesiologists work for a certain number of hours per shift and when they go off shift, another anaesthesiologist takes over. Each anaesthesiologist necessarily relies on the accuracy of the documented information from prior treaters.

[118] It follows that I accept Dr. Wang's evidence that the plaintiff arched her back during a contraction immediately preceding the needle fracture, notwithstanding the plaintiff and Mr. Welsh deny the plaintiff did so.

[119] The plaintiff suggests that Dr. Wang did not freeze the skin with lidocaine at the second location and that the resulting pain could have been a cause of her arching her back if she did, though she maintains she did not do so. As for Dr. Wang, she has no specific recollection of using lidocaine but again relies on her standard practice that she

would have done so. Ultimately it is not an issue I need to resolve, however. The plaintiff's argument is not that the needle fracture caused her injury but rather it was Dr. Wang's overmanipulating of the needle in the tissue. As such, the question of whether the plaintiff's arching of her back caused the needle to break is not significant.

[120] I accept that Dr. Wang made only two attempts to administer the epidural. All parties agree that the first attempt was unsuccessful but uneventful.

[121] As for the second attempt, Dr. Wang's evidence was that she believes she made two or three redirections. Although the plaintiff and Mr. Welsh referred to four attempts, I conclude there were only two. Rather, the third and fourth attempts, as they were referred to by both the plaintiff and Mr. Welsh, were redirections as part of the second attempt. Since I do not accept that Mr. Welsh could see the tip of the needle and since the plaintiff could not see her lower back and her skin had been frozen with lidocaine, I conclude that what each of them believed were new attempts were actually redirections. To that extent, the evidence of Mr. Welsh and the plaintiff is consistent with Dr. Wang's.

[122] Dr. Wang recalls some aspects of her epidural attempt. When the plaintiff arched her back, Dr. Wang recalled that the needle then hit bone, which required it to be withdrawn. It was at this point that Dr. Wang felt a loss of resistance, which was followed by her observation that a portion of the needle was retained in the plaintiff's back.

[123] Dr. Wang has some other recollections of Ms. Williamson's epidural attempt. She recalls that Ms. Williamson was very anxious, had a high BMI and was short in stature. She recalls the ligaments being tough when she did the epidural and said that she had only had three or four prior cases with such tough ligaments, and only one since.

[124] Although I accept Nurse Dhindsa's evidence in its entirety, it is important to recognize its strengths and weaknesses. Nurse Dhindsa was not involved in the epidural attempt, and she attended to other matters during the procedure. She estimated that she was out of the room for approximately five of the 15 minutes between when Dr. Wang arrived and when the needle broke. It is therefore not

surprising that Nurse Dhindsa did not see the plaintiff arch her back during a contraction, as this would have been relatively brief.

[125] According to Dr. Wang, it takes approximately 10 minutes from when she arrives in a patient's room to prepare for the epidural attempt. In this case, notwithstanding the plaintiff's recollection to the contrary, Nurse Dhindsa's evidence was that she already had the plaintiff positioned seated on the bed with her feet dangling prior to Dr. Wang's arrival, which could mean a little less time was required for preparation. However, this would still leave the amount of time for Dr. Wang to have been physically attempting to administer the epidural to be five minutes or perhaps slightly longer.

[126] I find that the total elapsed time between when Dr. Wang first commenced her efforts to administer the obstetric epidural in the plaintiff from the commencement of the first attempt until the needle fractured was approximately 10 minutes. During that time, there was the uneventful first attempt that failed because the needle hit a blood vessel. The second attempt involved two or three redirections, at which point the needle broke. The needle was determined to be fractured shortly after the plaintiff arched her back, at which point the needle tip hit bone and was discovered to be fractured when Dr. Wang sought to withdraw the needle tip from the bony area.

[127] Dr. Wang said she may have been up to 10 minutes attempting to administer the epidural, and on cross-examination, she conceded that the vast majority of the time spent was at the second location. That said, she was not timing the attempt.

[128] Nurse Dhindsa's estimate was that it took Dr. Wang less than five minutes to prepare for the epidural attempt. Since Dr. Wang acknowledged that she was not timing any of the procedures, I accept Nurse Dhindsa's evidence and I therefore conclude that Dr. Wang spent 10 minutes attempting to administer the epidural, the vast majority of which was spent during the second attempt.

[129] Following the removal of the needle fragment, Dr. Wang had a discussion with a spinal surgeon who was content with what she had done. She ordered an X-ray which showed no needle fragment in the back, and a plastic surgeon was brought in to assess

the wound. Both were satisfied nothing further was required other than by way of follow up.

[130] Following the event, Dr. Wang took certain steps required by the hospital as part of a patient's safety learning report. She provided a summary of the facts to the four department heads in anaesthesia at the Surrey Memorial Hospital, and she also did some research regarding broken needles. The articles she found were the same ones as those identified by Dr. Ezer, the plaintiff's standard of care expert.

[131] Her understanding, upon review of the literature, is that although it is extremely rare for an epidural needle to break, it has happened before. It is more common with spinal injections as opposed to epidurals because thinner needles are used for spinals.

[132] I am satisfied that Dr. Wang's care of the plaintiff after the needle fracture was conducted properly and without incident. The needle fragment was removed, the sutures were properly administered, and the wound in the plaintiff's low back healed uneventfully.

Standard of Care

[133] The law with respect to the standard of care of physicians is well settled. The test was outlined by the Supreme Court of Canada in *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 33, 1995 CanLII 72:

> It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances. In the case of a specialist, such as a gynaecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent, who holds himself out as possessing a special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field: see *Wilson v. Swanson*, 1956 CanLII 1 (SCC), [1956] S.C.R. 804, at p. 817, *Lapointe v. Hôpital Le Gardeur*, 1992 CanLII 119 (SCC), [1992] 1 S.C.R. 351, at p. 361, and *McCormick v. Marcotte*, 1971 CanLII 52 (SCC), [1972] S.C.R. 18.

[134] The standard of care involves consideration of a number of factors. In *Wilson v. Byrne*, 2004 CanLII 20532, 2004 CarswellOnt 2314, the Court identified three factors as

informing what must be addressed in determining whether or not a physician has met the required standard:

> [19] Determining whether a doctor has met the standard of care of a "reasonable practitioner" requires consideration of: (i) the education, experience and qualifications of the doctor, (ii) the degree of risk involved in the procedure or treatment, and (iii) the equipment, facilities and other resources available: see Picard & Robertson, *Legal Liability of Doctors and Hospitals in Canada*, *supra* at 186.

[135] A doctor's education and qualifications are important because a specialist is expected to have a greater level of skill and knowledge than a generalist, such as a family physician: *ter Neuzen* at para. 33.

[136] The degree of risk associated with a procedure will inform the standard of care because the greater the risk, the higher the expectation will be that the doctor will endeavour to ensure that the risk be avoided.

Positions of the Parties

[137] The plaintiff argues that Dr. Wang failed to meet the requisite standard of care as follows:

a) she spent too long redirecting the needle at the second location, disrupting the structural integrity of the needle;

b) she redirected the needle deep within the plaintiff's tissue without drawing it back to the subcutaneous tissue first;

c) she redirected and repositioned the angle at significant angles;

d) she did not change out the needle when she knew or ought to have known that the integrity of the needle was or might be compromised;

e) she failed to respond to the plaintiff's pain complaints and request that the procedure cease; and

f) she applied too much pressure to the needle against the bone in circumstances which is evidenced by the needle's fracture.

[138] The defendant argues that Dr. Wang met the required standard of care in this case. She says Dr. Ezer's report is of limited value. She says that his report, which initially did not include his certification of his duty to the court, was prepared carelessly and that the initial version of his report did not even bear his signature. Following a *voir dire*, I allowed Dr. Ezer's report into evidence.

[139] The defendant says Dr. Ezer's report was focussed on the outcome, being the breaking of the needle, as opposed to what Dr. Wang actually did during the epidural attempt, which is impermissible reasoning because it leaves the physician effectively in the position of guaranteeing the outcome of a procedure which is not the law.

[140] She says the plaintiff has failed to establish a breach of the standard of care.

Discussion

[141] The plaintiff's theory is that her injury does not result from the needle fracture itself, but rather from an excessive manipulation of the needle tip in the tissue in her back. As such, the exact cause of the needle fracture is not particularly significant in and of itself, other than the plaintiff says it confirms that Dr. Wang failed to meet the requisite standard of care.

[142] I will start with Dr. Ezer's opinion, the plaintiff's expert anaesthetist on the question of the standard of care.

[143] While I accept that some of the defendant's criticisms about the quality of the written report may have some merit, I also accept the plaintiff's submission that Dr. Ezer is clearly very knowledgeable in his field and that his level of understanding and diligence became more apparent during his cross-examination. For example, when questions were put to him, he was able to recall small details contained within the Surrey Memorial Hospital records, which were over 200 pages.

[144] Dr. Ezer's evidence with regard to Dr. Wang's attempt to administer the obstetric epidural to the plaintiff was set out in his report as follows:

> Many times, during the epidural insertion process, the needle angle needs to be adjusted, and slight movements are acceptable. However, if the angle needs to be significantly adjusted, the needle should be withdrawn and re-inserted at another location.
>
> In this situation, the needle is presumed to have been near a bone structure, which is not uncommon during an epidural insertion. Dr. Wang used considerable force to redirect the needle rather than withdrawing it entirely. The force was applied to the bone to cause the needle to bend, generating a weak point. When the needle was straightened during withdrawal, the tip broke off. The excessive force that was used to change the angle of the needle is uncommon and not recommended during an epidural insertion.

[145] He clarified that he considered 'considerable force' and 'excessive force' to be synonymous for the purposes of his opinion.

[146] There is no evidence that Dr. Wang used either considerable or excessive force when she encountered bone during the attempt, nor that she tried to manipulate or redirect the needle through or by bone. Indeed, it was apparent that it would make no sense for her to do so as the needle cannot penetrate bone. Therefore, when the tip of the needle hits bone, there is no reason for the anesthetist to do anything other than to withdraw the needle and try again, either by way of a redirection or another attempt.

[147] As was evident throughout his cross-examination, Dr. Ezer's opinions appear to have been predicated on his assumption that epidural needles are built to withstand the normal forces associated with a labouring woman undergoing contractions:

> The 17-guage Tuohy needle is designed as a larger, thicker needle meant to withstand pressure and force when entering the epidural space. It is not meant to break or bend with the patient's contractions, or with strong ligament tissues.

[148] Dr. Ezer relied on the fact that the needle broke as proof that Dr. Wang must have done something wrong in her attempt to administer the epidural. During his evidence he said, "this needle cannot break", and said that the only way to break the needle would be through negligence. While it is perhaps tempting to infer that the only possible explanation for the needle breakage here is that Dr. Wang must have done something wrong, this would be impermissible reasoning. Rather, the plaintiff must

prove that the defendant failed to meet the standard of care, as opposed to inferring that she could not have done so based upon the outcome.

[149] The mere fact of an unfortunate event or undesired consequence is insufficient to establish a breach of the standard of care. The Court of Appeal in *Carlsen v. Southerland*, 2006 BCCA 214, confirmed that the focus of the analysis must be on the precise manner in which the surgeon was alleged to have breached the standard of care, as opposed to inferring negligence based on the result: para. 15.

[150] Similarly, in *Siever v. Interior Health Authority*, 2021 BCSC 880, the Court cautioned against starting with a poor outcome and working backwards because this can have the effect of holding the physician to a standard of perfection: para. 102. I conclude that this is what Dr. Ezer has done in his report.

[151] Dr. Ezer's opinion was directed to the forces that would be required to cause the needle to break, which was the primary focus of what he was asked by plaintiff's counsel in her letter of instruction to him dated May 23, 2023:

> Q5. In your opinion, what was the most likely cause of this epidural needle breaking during Dr. Wang's insertion?
>
> Q6. In your opinion did Dr. Wang's care and treatment of Ms. Williamson meet the requisite standard of care of an obstetric anesthetist?

[152] However, the plaintiff's argument in closing submissions was not that her injury was caused by the needle fracture, but rather was caused by the manipulation of the needle in the tissue. Dr. Ezer was not asked to provide his opinion on the standard of care as it relates to manipulation of an epidural needle in the tissue except in the context of the needle fracture.

[153] During cross-examination, Dr. Ezer assumed that Dr. Wang made multiple attempts and many redirections in forming his opinion that Dr. Wang's technique fell below the requisite standard care. However, Dr. Ezer did not provide evidence as to the number of attempts or of the number of redirections that might be considered to be reasonably prudent, nor of what an anaesthetist would consider too many. Nor did he state an assumption as to how many redirections and attempts were made by

Dr. Wang. Lastly, I concluded above that Dr. Wang spent approximately 10 minutes attempting to administer the epidural primarily at the second location. Dr. Ezer did not suggest that an anaesthetist should not spend approximately 10 minutes at a single location.

[154] There was also no evidence—referenced in Dr. Ezer's report or otherwise tendered by the plaintiff at trial—as to how many redirections an anaesthetist could safely attempt with a single needle, nor was there evidence that Dr. Wang did anything improper or unusual in her attempts to administer this epidural.

[155] I find that Dr. Ezer's conclusion that Dr. Wang breached the standard of care was based solely on the outcome of the attempts—the broken needle. There is no evidence that Dr. Wang attempted to redirect the needle because she had hit bone or that she applied excessive or considerable force in order to overcome bone. I conclude that this is simply a hypothetical possibility identified by Dr. Ezer in order to attempt to explain why the needle fractured.

[156] The defendant's expert on the standard of care was Dr. Head. Dr. Head is a Clinical Associate Professor of Anesthesiology, Pharmacology and Therapeutics at the University of British Columbia and has been an anesthesiologist since 2005. He practices neuraxial anesthesia at Royal Jubilee Hospital in Victoria, British Columbia.

[157] Dr. Head opined that there is no evidence that Dr. Wang failed to take reasonable precautions and employ the appropriate technique in attempting to place the epidural, notwithstanding the unfortunate complications. Even under ideal conditions, epidural placement can be challenging. Epidurals are typically not placed with the assistance of any real-time imaging guidance (e.g., ultrasound or MRI), and hence are done by feel. Dr. Head opined that the plaintiff's elevated BMI, her movement during contractions and her tough ligamentous tissue were all factors that made placement of the epidural technically challenging in this case. While contractions and body movements should be expected during the procedure, he disagreed that arching of the back was common.

[158] The Court heard evidence about the impact of an elevated BMI on an obstetric epidural attempt, with the argument being that the plaintiff's BMI affected the outcome of the procedure. BMI is an arithmetic calculation where a person's weight in kilograms is divided by the square of their height in meters. A BMI over 30 is considered obese. An elevated BMI can have two effects on an epidural. First, if a patient has a lot of fatty tissue in the back, it can be more difficult to find the bony structures by feel, referred to as landmarking. The second effect is that if there is a lot of fatty tissue, the epidural space may be much deeper from the skin, which can mean that a regular epidural needle may not be long enough.

[159] I do not accept that the plaintiff's BMI was a significant factor in this case, nor do I accept that the plaintiff's BMI was outside of normal ranges. As Dr. Ezer said, since BMI is simply a calculation based on weight and height, almost all pregnant women have an elevated BMI. Dr. Wang did not indicate any issue with landmarking the plaintiff's bony structures.

[160] Both parties referred to some articles that reported on broken obstetric epidural needles. I accept that there are instances in the medical literature where epidural needles have broken. However, I also accept that it is an extremely rare event and epidurals are routinely administered throughout the world without incident.

[161] The 17-gauge Tuohy needle is a hollow, thin piece of metal. It is not indestructible. It could presumably be compromised in a number of ways, including repeated bending back and forth, leading to metal fatigue. Presumably if sufficient axial force were applied, it could break as well. Dr. Head agreed during cross-examination that the structural integrity of the needle could in theory be compromised if over manipulated. The retained needle fragment that was removed from the plaintiff's back was bent in the shape of a "U". Unfortunately, the fragment was not retained after removal and was disposed of by Dr. Wang in the sharps container in accordance with standard practice.

[162] There is no evidence that Dr. Wang made too many redirections, or that she did not withdraw the tip of the needle to the subcutaneous layer prior to attempting

redirections. While it is hypothetically possible that the needle could fatigue and become compromised if redirections were attempted without withdrawing the tip to the subcutaneous layer, there is no evidence that this is what Dr. Wang did. Nor is there evidence that the defendant persevered for too long on any of her attempts, or that the standard of care requires an anaesthesiologist to use a new needle after a certain number of attempts or redirections.

[163] Absent any evidence of the standard of care with regard to the mechanics of an obstetric epidural, it is not possible for the Court to conclude that the defendant's epidural attempt was not in accordance with standard practice.

[164] In his report, Dr. Head indicated that the Department of Anaesthesia in Victoria had numerous experiences with epidural needles made by the same manufacturer which were found to be overly ductile (i.e., easily deformed) resulting in a higher than normal incidence of bent or deformed needle tips. This report was in 2020, one year after the epidural in this case. However, this evidence is of no real value. At best it is anecdotal, and there is no evidence that there were problems before or after 2020. There is also no evidence either that the needle used by Dr. Wang was from the same batch that the anaesthesiologists in Victoria were referring to.

[165] Alternatively, even if Dr. Ezer was correct in concluding that Dr. Wang used considerable or excessive force, this would not give rise to a plausible explanation regarding damage to the tissue in the plaintiff's back, even if it could explain why the needle broke.

[166] In all of the circumstances, while this was undoubtedly an unfortunate event, the plaintiff has failed to prove that Dr. Wang's actions fell below the standard of care to be expected of an anaesthesiologist attempting to administer an obstetrical epidural. Simply put, there is no evidence that the number of attempts, the number of redirections and the amount of time spent attempting to administer the epidural by Dr. Wang were inconsistent with the standard of care to be expected in all of the circumstances, or that her technique was in any way improper.

Causation

[167] If a defendant is found not to have met the required standard of care, that does not, in and of itself, make that defendant liable for a plaintiff's injuries. A plaintiff must establish a causal link between the doctor's negligence and the injury. The 'but for' test applies in medical malpractice cases, no different than other claims in negligence.

[168] The majority of the Supreme Court of Canada explained this in *Benhaim v. St-Germain*, 2016 SCC 48:

> [54] In sum, the Court held in *Snell* that "the plaintiff in medical malpractice cases — as in any other case — assumes the burden of proving causation on a balance of the probabilities": *Ediger*, at para. 36. Causation need not be proven with scientific or medical certainty, however. Instead, courts should take a "robust and pragmatic" approach to the facts, and may draw inferences of causation on the basis of "common sense": *Snell*, at pp. 330-31; *Clements*, at paras. 10 and 38. The trier of fact may draw an inference of causation even without "positive or scientific proof", if the defendant does not lead sufficient evidence to the contrary. If the defendant does adduce evidence to the contrary, then, in weighing that evidence, the trier of fact may take into account the relative ability of each party to produce evidence: *Ediger*, at para. 36.

[169] The 'but for' test remains the law, but the court may draw inferences based on human experience and common sense. In *Clements v. Clements*, 2012 SCC 32, the trial judge was found to have made an error by requiring scientific accident reconstruction evidence to establish what occurred in a motorcycle collision. The Court stated as follows at paras. 8 and 9:

> The test for showing causation is the "but for" test. The plaintiff must show on a balance of probabilities that "but for" the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence *was necessary* to bring about the injury — in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.
>
> The "but for" causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury. See *Wilsher v. Essex Area Health Authority*, [1998] A.C. 1074 (H.L.), at p. 1090, per Lord Bridge; *Snell v. Farrell,* [1990] 2. S.C.R. 311.

[170] In *Benhaim*, the Supreme Court of Canada concluded that inferences can be drawn with regard to causation fact-finding, no different than in other fact-finding situations. As such, the "but for" test remains, and there is no reverse onus situation created in medical malpractice cases on the issue of causation.

[171] From a practical perspective, assuming a plaintiff's explanation of his or her symptoms before and after the incident are accepted, the analysis may be as simple as considering whether the incident is the only possible reasonable or plausible explanation for the plaintiff's injury. While the defendant does not have the burden to disprove causation, offering plausible alternative theories of causation may serve to undermine the plaintiff's position.

Positions of the Parties

[172] The plaintiff's position is that she did not suffer from back pain prior to the failed epidural, and that the epidural is therefore the most likely explanation. Her position is supported by the opinion of Dr. Ramesh Sahjpaul, a neurosurgeon called by the plaintiff. According to Dr. Sahjpaul, the epidural needle itself incites a certain amount of trauma and the degree of the trauma correlates with the specific facts of the case, including the number of attempts, and the length of the attempt.

[173] The defendant concedes that the plaintiff experiences back pain but says it is not as a result of the failed epidural. Instead, the defendant submits the pain is a result of degenerative changes in her back evidenced by the MRIs. The defendant relies on the opinion of Dr. Heather Finlayson, a physiatrist retained by the defence. Dr. Finlayson's opinion is that the plaintiff has mechanical back pain resulting from those degenerative changes, unrelated to the epidural attempt.

[174] Before addressing the conflicting opinion evidence, there were a few matters raised in the export reports but were not pursued as the trial progressed. It was suggested by Dr. Ezer that the plaintiff would not have needed a caesarian section had the epidural been conducted differently. I do not agree. Subsequent to the failed epidural attempt, there was also a subsequent unsuccessful attempt at a spinal anesthetic. The plaintiff had been declining vaginal examinations since the previous

evening due to discomfort. The labouring process had been extremely difficult and uncomfortable for the plaintiff, and the fact that her baby was very large and she was two weeks overdue were likely contributing factors. A caesarian section was inevitable.

[175] It was also suggested by Dr. Ezer that Dr. Wang went beyond the scope of expertise of an anesthetist when she surgically removed the needle fragment. Dr. Head's opinion was to the contrary. The removal of the retained needle fragment was by all accounts conducted successfully and appropriately. I accept that in a larger centre where Dr. Ezer practices, it is less likely that the anesthetist would have conducted the surgical excision. However, I do not find that Dr. Wang, as a properly qualified medical doctor, was acting outside of her scope of expertise when conducting this relatively simple procedure, and nothing turned on it in any event.

Discussion

[176] Dr. Sahjpaul was qualified as an expert in spinal neurosurgery and also chronic pain management. He treats workers and provides opinions to WorkSafeBC on those who present with spinal injuries. In some cases, he performs surgery, and he otherwise makes referrals to other treatment providers. He is not an expert on emotional and psychological matters, but recognizes the symptoms and makes referrals accordingly.

[177] Dr. Sahjpaul prepared his report following an examination of the plaintiff, review of the medical records, and his interview with the plaintiff. The plaintiff relies on Dr. Sahjpaul's evidence to support her position that her ongoing back pain is as a result of the epidural attempt. Dr. Sahjpaul's opinion is as follows:

> Summary and Opinions
>
> Ms. Williamson is a previously healthy woman with no past history of spinal issues. On March 25, 2019, she underwent an epidural anesthetic that resulted in a fractured epidural needle requiring a surgical incision to remove the needle. In my opinion, as a result of the incident, she has sustained a traumatic injury to the lumbar spine area resulting in back pain which has reduced over time, but not resolved. Removal of the needle also required a surgical incision and subsequent scar which is also bothersome to her.
>
> In my opinion, as a result of the March 25, 2019 epidural incident, she has developed chronic pain syndrome involving her low back which is due to the epidural attempt and needle fracture and subsequent surgical incision required

> for needle removal. This incident has resulted in myofascial/soft tissue injury chronic pain.

[178] Dr. Sahjpaul's physical examination of the plaintiff was normal and, as such, his conclusions are derived from the other two sources—the medical records and his interview of the plaintiff. As for the medical records, he was provided with the first of the plaintiff's MRIs. The MRI noted degenerative changes, but in the absence of radiculopathy, or nerve-related complaints radiating down either or both legs, he did not consider those degenerative changes to be causative of her pain symptoms. As such, he provided the opinion that her ongoing back issues are related to the failed epidural attempt.

[179] There are a couple of difficulties with Dr. Sahjpaul's opinion, however.

[180] First, Dr. Finlayson provided a rebuttal report to Dr. Sahjpaul's report. Dr. Finlayson highlighted that Dr. Sahjpaul did not provide an anatomic and physiological explanation for how the plaintiff's ongoing symptoms would be related to the failed epidural. While it is not difficult to imagine that numerous attempts to insert a sharp needle through tissue could cause trauma to that tissue, Dr. Finlayson's criticism is valid, keeping in mind a successfully administered epidural must also penetrate the tissue.

[181] Second, and more importantly, Dr. Sahjpaul's opinion included the following:

> In my opinion, she is not at risk for developing more pain and/or neurological symptomology or deficits absent further trauma.

[182] Dr. Sahjpaul's examination of the plaintiff was conducted on June 16, 2023. The plaintiff has since reported pain radiating down her legs, and the plaintiff's family physician, Dr. Mathew, felt it prudent to send the plaintiff for a third MRI which was conducted a few weeks before the trial. The results were not available at the time of trial.

[183] While nothing necessarily would turn on the result of the third MRI, Dr. Sahjpaul's theory on causation would suggest that if her symptoms were caused by the trauma

from the epidural, her symptoms would not have worsened absent a subsequent trauma. However, this turned out not to be the case. As such, while his conclusion might have been reasonable had nothing changed, it is undermined by subsequent symptoms arising, including radiating pain into her legs.

[184] I accept Dr. Sahjpaul's observation that there is not necessarily a connection between degenerative changes revealed on an MRI and pain symptoms, and that a person can have pain even if the imaging is normal, a person with degenerative changes may have no pain at all, the fact that the plaintiff's symptoms have continued to worsen over time would suggest that it is more likely than not that the symptoms are caused by degenerative changes and not by the epidural attempt in the plaintiff's case.

[185] In all of the circumstances, I accept Dr. Finlayson's opinion that the plaintiff's symptoms are as a result of her mechanical back pain. She has been receiving treatment for mechanical back pain since shortly after the birth of her first child, primarily at the direction of her family physician.

[186] Dr. Finlayson conducted a physical examination of the plaintiff. She found the plaintiff's symptoms to be consistent with the diagnosis of mechanical back pain, which she defines as pain originating in her muscles, tendons, ligaments, and joints of the lumbar spine. Her report of December 19, 2023 includes the following:

> Her physical examination supports the diagnosis of mechanical back pain. During my assessment, her back pain was most pronounced with extension (leaning backwards), and with extension combined with rotation to each side. She was tender when I applied pressure over the area of the lower lumbar facet joints. These are all expected findings of mechanical back pain. There was no tenderness directly along the scar on her back, although she reported that it felt numb over the area of the scar and just above it, which is common around scars. The neurological examination of her legs was normal, such that there was no indication of a nerve injury or spinal cord dysfunction contributing to her symptoms. She had an elevated body mass index, an increased lumbar lordosis (arch of the low back), and pronounced pes planus (flatfeet). These latter three body features are ail risk factors for mechanical back pain.
>
> Ms. Williamson has had imaging of her low back with x-rays and an MRI of the lumbar spine. These confirmed that there was no retained needle fragment following the epidural procedure. The imaging showed degenerative changes ("wear and tear" arthritis) at multiple levels of her spine, greatest at L4-5 and L5-S1 (joints at the very base of the spine). This included signs of osteoarthritis in

> the facet joints, narrowing of the space between the joints, and disc herniations. These changes were more pronounced than average for someone of her age. These findings strongly support the diagnosis of mechanical back pain in the context of Ms. Williamson's history and physical examination findings.

[187] While Dr. Mathew was called as a fact witness and not as an expert, I do have the benefit of Dr. Finlayson's opinion which ostensibly accords with Dr. Mathew's assessment that has informed his treatment recommendations.

[188] A successful epidural requires the needle tip to pass through all of the ligamentous tissue before it reaches the epidural space. It is therefore presumably the case that the needle always pierces the tissue in the patient's back. As discussed, there is no evidence that the attempt by Dr. Wang was unusual in any way, other than the outcome regarding the needle fracture.

[189] In all of the circumstances, the plaintiff has not proven that her back pain is as a result of tissue damage caused by the redirections and manipulations of the needle.

Disposition

[190] The plaintiff's claim against the defendant is dismissed.

[191] If either of the parties wishes to address the issue of costs, they may contact Supreme Court Scheduling within 21 days of these reasons to arrange to speak to the matter.

"Wilson J."